

COPY



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November 4, 2010

Susan Broetje, Administrator
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **October 28, 2010**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004801

Allegation #1: Staff do not intervene in maladaptive behavior in a timely manner, resulting in injury to individuals.

Findings #1: An unannounced on-site complaint investigation was conducted on 10/27/10 and 10/28/10. During that time, investigations, and individuals' records were reviewed. Additionally, observations and interviews with program staff and direct care staff were conducted with the following results:

Ten investigations were reviewed with one investigation documenting a significant injury due to self injurious behavior. The investigation's action plan documented the behavior program for this individual contained insufficient directions to staff related to self injurious behavior. The facility updated the behavior program and provided written directions on what to do when the individual engaged in self injurious behavior on 10/15/10 and provided formal training on 10/20/10.

Observations were conducted on 10/27/10 and 10/28/10 for a cumulative 5 hours 38 minutes. During that time, no individuals were noted to engage in maladaptive

behaviors.

Additionally, the behavior programs for 10 individuals were reviewed. All of the plans included information related to the individuals' maladaptive behaviors and instructions to staff regarding how to intervene when maladaptive behaviors occurred. Three clinicians were interviewed and explained the training process for staff related to behavioral programs and 27 direct care staff were interviewed. All staff consistently reported they were trained on behavior programs on a monthly basis and trained as updates to programs occurred or new programs were implemented.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Guardians are not notified of significant events.

Findings #2: An unannounced on-site complaint investigation was conducted on 10/27/10 and 10/28/10. During that time, investigations were reviewed and staff interviews were conducted with the following results:

Ten investigations were reviewed. All investigations consistently documented guardian contacts in accordance with guardian requests and facility policy.

Two Social Workers were interviewed on 10/27/10. Both social workers presented a caseload document for each individual on their caseload that recorded all guardian contacts. The document showed guardians were contacted for clinic appointments, meetings, referrals, moves, work changes, discharge eligibility, and significant event reports. Further, both stated in the event of a significant event report, nursing staff initially attempted guardian contact. If nursing staff was unsuccessful, the social worker was then responsible for guardian notification. Additionally, one social worker stated if attempts to contact the guardian by way of telephone were unsuccessful a letter was then sent to the guardian. The social workers both stated that notification was guided by guardian preference.

It could not be established that guardians were not being notified of significant events. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.


Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan


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of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,


JAMES TROUFFETTER
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/srm